STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005035	A. BUILDING: _____ B. WING _____	C 12/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK REGIONAL HOSPITAL	801 N STATE ST GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of one State complaint. Complaint Number: #IN00144445 Unsubstantiated; lack of sufficient evidence. Date of survey: 12/23/2014 Facility #: 005035 Surveyor: Nancy Otten, RN Public health Nurse Surveyor Hancock Regional Hospital is in compliance with 410 IAC 15-1.5-10 Discharge planning services, Indiana Hospital Licensure Rules.	S 000		